REQUEST TO ACCESS PROTECTED HEALTH INFORMATION BY PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

File Number:_____

You have the right to request to inspect protected health information in records which Medi-Cal creates or maintains. You also have the right to request copies of those records. You will be charged for the cost of copying and postage. You will receive a response to your request within 30 days after we receive your request. If you want copies of records mailed, you need to send us a photocopy of your California driver's license, an identification card issued by the Department of Motor Vehicles or other valid identification. You will also need to send documentation verifying your address. Mail this completed form to:

Department of Health Services
EDS Communications
P.O. Box 526018
Sacramento, CA 95852-6018

INDIVIDUAL WHOSE INFORMATION YOU ARE REQUESTING			
LAST NAME:	FIRST NAME:		MIDDLE INITIAL:
ADDRESS:	CITY/STATE:		ZIP CODE:
BENEFICIARY ID NUMBER:	DATE OF BIRTH:	DATE OF DEATH: (IF APPLICABLE)	
DEATH CERTIFICATE MUST BE ATTACHED			
PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE INFORMATION			
LAST NAME:	FIRST NAME:		MIDDLE INITIAL:
ADDRESS:	CITY/STATE:		ZIP CODE:

DAYTIME TELEPHONE NUMBER: ( )	EVENING TELEPHONE NUMBER: ( )	EMAIL ADDRESS:	BEST HOURS TO REACH YOU:

WHAT LEGAL AUTHORITY DO YOU HAVE TO REQUEST HEALTH INFORMATION OF THE INDIVIDUAL ABOVE?

☐ PARENT
☐ CONSERVATOR
☐ GUARDIAN
☐ EXECUTOR OF WILL
☐ MEDICAL POWER OF ATTORNEY
☐ OTHER

PLEASE ATTACH LEGAL DOCUMENTATION VERIFYING THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE INDIVIDUAL.

PROTECTED HEALTH INFORMATION YOU WANT TO ACCESS

WHAT TYPE OF PROTECTED HEALTH INFORMATION DO YOU WANT TO ACCESS?

☐ SUMMARY OF PAYMENTS MADE BY MEDI-CAL (CLAIM DETAIL REPORT)
☐ CASE MANAGEMENT RECORDS
☐ TREATMENT AUTHORIZATION REQUESTS
☐ OTHER _____
☐ OTHER _____

PLEASE BE SPECIFIC AS YOU WILL BE CHARGED FOR EACH PAGE COPIED.

FOR WHAT TIME PERIOD DO YOU WANT INFORMATION?

FROM DATE:	TO DATE:

METHOD TO ACCESS REQUESTED HEALTH INFORMATION

☐ PLEASE MAIL ME A COPY OF THE REQUESTED INFORMATION TO THE ADDRESS INDICATED ON PAGE ONE OF THIS FORM.

☐ I WISH TO REVIEW THE REQUESTED INFORMATION IN PERSON.

IF YOU REQUEST TO REVIEW RECORDS IN PERSON, YOU WILL BE CONTACTED TO SCHEDULE AN APPOINTMENT.

LOCATION AVAILABLE FOR IN-PERSON REVIEW: **SACRAMENTO ONLY**

IDENTIFYING INFORMATION

☐ COPY OF IDENTIFICATION ATTACHED

TYPE:_____ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFICIARY IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD)

NUMBER:_____

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

REPRESENTATIVE SIGNATURE: DATE:

(IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.)

NOTARIZED BY: _____ ON _____ (DATE)

NOTARY PUBLIC NUMBER: _____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC:

☐ ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION _____ (UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.)

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.